

**INSTRUCTIONS  
RESIDENT AUTHORIZATION FORM**

**A. PERMISSION TO PURSUE COMPLAINT**

- 1. The name of the regional ombudsman or community advisory committee member who received the complaint must appear on the form.**
- 2. The name of the facility must also appear on the form.**
- 3. The signature of the resident and the date signed must appear on the form. The signed form is to be attached to the Case Record on the complaint and kept in the regional ombudsman's confidential files.**

**B. PERMISSION TO REVIEW MEDICAL/SOCIAL/FINANCIAL RECORDS**

- 1. The name of the regional ombudsman or community advisory committee member whom the resident or legal representative gives written permission to have access to the resident's medical/social/financial records must appear on the form.**
- 2. The name of the resident as well as the name of the facility must appear on the form in the appropriate blanks.**
- 3. The signature of the resident or legal representative who gives permission for the regional ombudsman or the community advisory committee member to have access to the resident's medical/social/financial records and the date must appear on the form.**
- 4. If the resident uses an "X" as a signature or is otherwise unable to write his/her name, have the mark executed by the resident witnessed by someone other than the regional ombudsman or the community advisory committee member.**

## RESIDENT AUTHORIZATION FORM

Your signature on this Resident Authorization Form gives written consent for the Regional Ombudsman and/or Community Advisory Committee to pursue complaint resolution on your behalf. The signed form is kept in the Regional Ombudsman's file.

### A. Permission to Pursue Complaint

\_\_\_\_\_ (Name) \_\_\_\_\_ (Title)

has my permission to discuss the complaint(s) I have regarding my care with the administration and staff of \_\_\_\_\_ (Facility)

as well as with other individuals deemed necessary to resolve the complaint(s).

\_\_\_\_\_ yes \_\_\_\_\_ no

I also give permission for my name to be disclosed in the complaint resolution process.

\_\_\_\_\_ yes \_\_\_\_\_ no

\_\_\_\_\_ Signature of Resident \_\_\_\_\_ Date

## RESIDENT AUTHORIZATION FORM

### B. Permission to Review Medical/Social/Financial Records

\_\_\_\_\_  
(Name) (Title)  
has my permission \_\_\_\_\_ to view my  
(Resident's Name)  
medical/social/financial records in order to pursue complaint resolution on my  
behalf at \_\_\_\_\_.  
(Facility)

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date